

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00672

677

CERTIFICATE OF DEATH

Reg. Dist. No. 186

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>15 hrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Churchville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Jasper</u> Middle <u>Buren</u> Last <u>Andrews</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>17</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH <u>July, 6, 1904</u>		9. AGE (In years lost birthday) <u>52</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Jasper Andrews</u>			14. MOTHER'S MAIDEN NAME <u>Laura Sexton</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>242-22-3251</u>	17. INFORMANT <u>Lelia Phipps, Belcamp Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - posterior, with myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>about 12 hrs.</u> ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>① Bronchopneumonia - bilateral ② Emphysema - bilateral</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Jan. 16th, 1957</u> to <u>Jan. 17th, 1957</u> , that I last saw the deceased alive on <u>17 JANUARY, 1957</u> , and that death occurred at <u>10:20</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Haver de Grace, Ind.</u>		DATE SIGNED <u>1/17/57</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	22b. DATE THEREOF <u>Jan. 18, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Reins-Sturdivant Co.</u>	22d. LOCATION (City, town, or county) (State) <u>Sparta, Allegheny, N.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McComas & Son</u>		ADDRESS <u>Abingdon Md.</u>	24a. REC'D BY REGISTRAR <u>Jan 21-57</u>	24b. REGISTRAR'S SIGNATURE <u>G. L. Kershner</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		MARRIAGE		RELIGION	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		COUNTRY	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
DATE OF BURIAL		PLACE OF BURIAL		CITY		COUNTY		STATE		COUNTRY	
NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CHURCH		NAME OF CEMETERY		NAME OF INTERVIEWER		NAME OF WITNESS	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF CEMETERY		SIGNATURE OF INTERVIEWER	
DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY		COUNTY		STATE		COUNTRY	

BUREAU V. S.

JAN 22 1957

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 3

JAN 8 1957

RECEIVED

697

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen R.D.				c. LENGTH OF STAY IN 1b 30 yrs.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Calvary			
3. NAME OF DECEASED (Type or print) First John Middle Baden Last Baden				4. DATE OF DEATH Month Jan. Day 20 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1876		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mary Baden Address Aberdeen R.D. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic C. V. Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 7 das 6
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Cataracts							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 1956 , to Jan 1957 , that I last saw the deceased alive on Jan 19 1957 , and that death occurred at 3 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Churchville Md DATE SIGNED Jan 22 ACTUAL SIGNATURE Ralph Horky M.D. Churchville Md PHYSICIAN'S NAME (Type) Ralph Horky MD Churchville Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McCombs & Son				ADDRESS Abingdon Md.		24a. REC'D BY REGISTRAR DATE Jan 24 57	
				24b. REGISTRAR'S SIGNATURE Stellie H. Perry			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 3

JAN 28 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grafton Shop Rear</u>		c. LENGTH OF STAY IN 1b <u>?</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forest Hill R.D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MINNIE JANE BRUFFEY</u>		4. DATE OF DEATH <u>Jan. 2</u> 19 <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 12, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>No. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>No. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Auston Brown</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs Harvey Fristoe Forest Hill R.D.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Embolic from Heart (Auricular fibrillation)</u> DUE TO (c) <u>Chr. myocardial disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-29-56</u> , 19 <u>56</u> , to <u>1-2-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-2-57</u> , 19 <u>57</u> , and that death occurred at <u>1:25</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 5, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Tarrettsville</u>	22d. LOCATION (City, town, or county) (State) <u>Tarrettsville Harford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion G. Huntz Tarrettsville</u>		24a. REC'D BY REGISTRAR <u>DATE 1-7-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bevilla Howard</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. S.

JAN 9 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO REGISTRAR: File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00676

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 180-

679

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DDA Harford Memorial Hospital</u>		d. STREET ADDRESS <u>RD 1 07X12</u>	
3. NAME OF DECEASED (Type or print) First <u>Richard C.</u> Middle <u>Buzzell</u> Last <u>Buzzell</u>		4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9 - 1957</u> <u>days</u> yrs.
9. AGE (In years last birthday) <u>days</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	11. BIRTHPLACE (State or foreign country) <u>Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Howard Buzzell</u>	
14. MOTHER'S MAIDEN NAME <u>Berulah Hawley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. <u>Berulah Buzzell, Perryville, Md. Rural.</u>		17. INFORMANT <u>Berulah Buzzell, Perryville, Md. Rural.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental aspiration vomitus</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C. Palmer</u> EXAMINER'S NAME (Type) <u>Gerald C. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Harford County</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-17-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Deer Creek Harmony</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leed Patterson & Son, Perryville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>1-16-57</u>	
24b. REGISTRAR'S SIGNATURE <u>G. A. Lewis M.D.</u>		DATE SIGNED <u>1-16-57</u>	

2017272XV5

RECEIVED

JAN 17 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

699 CERTIFICATE OF DEATH

Reg. Dist. No.

00677

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital				d. STREET ADDRESS 113M Rodman Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Michael Arthur Cantrell				4. DATE OF DEATH Month Day Year January 7 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 28, 1956		9. AGE (In years last birthday) yrs. Months Days 2 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Claud Franklin Cantrell				14. MOTHER'S MAIDEN NAME Gladys Marjorie Tirell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Father as in 2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden unexplained death DOA 795.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. s. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 28, 1956 to January 2, 1957 , that I last saw the deceased alive on January 2, 1957 , and that death occurred at 6:55a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Hreidar Agustsson</i>		M.D. US Army Hospital				DATE SIGNED Jan 8, 1957	
PHYSICIAN'S NAME (Type) HREIDAR AGUSTSSON, Major, MC		Aberdeen Proving Ground, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Jan 8 1957		22c. NAME OF CEMETERY OR CREMATORY Orange Cemetery		22d. LOCATION (City, town, or county) (State) New Haven Conn	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Garring</i>		ADDRESS Aberdeen Md.		24a. REC'D BY REGISTRAR DATE Jan 8-57		24b. REGISTRAR'S SIGNATURE <i>Nellie R Perry</i>	

2006302XV4

CERTIFICATE OF DEATH

<p>1. Name of deceased: James Earl Ray</p>		<p>2. Date of death: May 14, 1968</p>	
<p>3. Place of death: Prison, St. Louis, Missouri</p>		<p>4. Cause of death: Heart disease</p>	
<p>5. Age at death: 35 years</p>		<p>6. Sex: Male</p>	
<p>7. Race: White</p>		<p>8. Marital status: Single</p>	
<p>9. Birth date: January 5, 1933</p>		<p>10. Birth place: Alton, Illinois</p>	
<p>11. Occupation: Writer</p>		<p>12. Education: High School</p>	
<p>13. Social Security Number: 3-087-1234</p>		<p>14. Signature of physician: [Signature]</p>	
<p>15. Signature of registrar: [Signature]</p>		<p>16. Date of registration: May 15, 1968</p>	

BUREAU V. S.

JAN 11 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 006781

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Near Gladwin</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Zella</u> Middle <u>E</u> Last <u>Black</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 11 1868</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Party</u>		14. MOTHER'S MAIDEN NAME <u>Harold Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wesley P. Miller</u>		Address <u>Balto road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 422.1 DUE TO <u>Arterio-sclerotic Cardio-vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 15, 1957</u> to <u>Jan 15, 1957</u> , that I last saw the deceased alive on <u>Jan 15, 1957</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Ralph Horky</u> M.D.		ADDRESS (Street, city or town, state) <u>Churchville Md</u>	
PHYSICIAN'S NAME (Type) <u>J. Ralph Horky MD</u>		DATE SIGNED <u>Jan 18</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 18 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Harming</u>		ADDRESS <u>Aberdeen Md</u>	
24a. REC'D BY REGISTRAR <u>Jan 18 57</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie R Perry</u>	

BUREAU V. S.

1957 21 JAN

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00679

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, Rural		c. LENGTH OF STAY IN 1b 31	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescing Home		d. STREET ADDRESS Parke Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BLANCHE Middle BOLTON Last CLOTWORTHY		4. DATE OF DEATH Month January Day 30 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1870
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel F. Bolton		14. MOTHER'S MAIDEN NAME Eliza C.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Baker Clotworthy		Address 4404 Sadgwk. Rd. Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr. decompensated Cardio-Vasc. Disease with auricular fibrillation DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 15 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 21 , 19 56 , to Jan. 30 , 19 57 , that I last saw the deceased alive on Jan. 22 , 19 57 , and that death occurred at 6:00aM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED 1-30-57			
ACTUAL SIGNATURE Willard P. Hudson M.D. Forest Hill, Md.			
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1 Feb. 57	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Sarny		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR DATE 1-31-57		24b. REGISTRAR'S SIGNATURE Prueille Lowood	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
JAMES EARL RAY		Male		35		May 1922		Memphis, Tenn.		Attorney		Heart Disease		Natural	
9. PLACE OF DEATH		10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
St. Louis, Mo.		May 1, 1968		10:00 AM		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. COUNTY		22. CITY		23. STATE		24. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
25. COUNTY		26. CITY		27. STATE		28. ZIP CODE		29. COUNTY		30. CITY		31. STATE		32. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
33. COUNTY		34. CITY		35. STATE		36. ZIP CODE		37. COUNTY		38. CITY		39. STATE		40. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
41. COUNTY		42. CITY		43. STATE		44. ZIP CODE		45. COUNTY		46. CITY		47. STATE		48. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
49. COUNTY		50. CITY		51. STATE		52. ZIP CODE		53. COUNTY		54. CITY		55. STATE		56. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
57. COUNTY		58. CITY		59. STATE		60. ZIP CODE		61. COUNTY		62. CITY		63. STATE		64. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
65. COUNTY		66. CITY		67. STATE		68. ZIP CODE		69. COUNTY		70. CITY		71. STATE		72. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
73. COUNTY		74. CITY		75. STATE		76. ZIP CODE		77. COUNTY		78. CITY		79. STATE		80. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
81. COUNTY		82. CITY		83. STATE		84. ZIP CODE		85. COUNTY		86. CITY		87. STATE		88. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
89. COUNTY		90. CITY		91. STATE		92. ZIP CODE		93. COUNTY		94. CITY		95. STATE		96. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
97. COUNTY		98. CITY		99. STATE		100. ZIP CODE		101. COUNTY		102. CITY		103. STATE		104. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
105. COUNTY		106. CITY		107. STATE		108. ZIP CODE		109. COUNTY		110. CITY		111. STATE		112. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
113. COUNTY		114. CITY		115. STATE		116. ZIP CODE		117. COUNTY		118. CITY		119. STATE		120. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
121. COUNTY		122. CITY		123. STATE		124. ZIP CODE		125. COUNTY		126. CITY		127. STATE		128. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
129. COUNTY		130. CITY		131. STATE		132. ZIP CODE		133. COUNTY		134. CITY		135. STATE		136. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
137. COUNTY		138. CITY		139. STATE		140. ZIP CODE		141. COUNTY		142. CITY		143. STATE		144. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
145. COUNTY		146. CITY		147. STATE		148. ZIP CODE		149. COUNTY		150. CITY		151. STATE		152. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
153. COUNTY		154. CITY		155. STATE		156. ZIP CODE		157. COUNTY		158. CITY		159. STATE		160. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
161. COUNTY		162. CITY		163. STATE		164. ZIP CODE		165. COUNTY		166. CITY		167. STATE		168. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
169. COUNTY		170. CITY		171. STATE		172. ZIP CODE		173. COUNTY		174. CITY		175. STATE		176. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
177. COUNTY		178. CITY		179. STATE		180. ZIP CODE		181. COUNTY		182. CITY		183. STATE		184. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
185. COUNTY		186. CITY		187. STATE		188. ZIP CODE		189. COUNTY		190. CITY		191. STATE		192. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
193. COUNTY		194. CITY		195. STATE		196. ZIP CODE		197. COUNTY		198. CITY		199. STATE		200. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
201. COUNTY		202. CITY		203. STATE		204. ZIP CODE		205. COUNTY		206. CITY		207. STATE		208. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
209. COUNTY		210. CITY		211. STATE		212. ZIP CODE		213. COUNTY		214. CITY		215. STATE		216. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
217. COUNTY		218. CITY		219. STATE		220. ZIP CODE		221. COUNTY		222. CITY		223. STATE		224. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
225. COUNTY		226. CITY		227. STATE		228. ZIP CODE		229. COUNTY		230. CITY		231. STATE		232. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
233. COUNTY		234. CITY		235. STATE		236. ZIP CODE		237. COUNTY		238. CITY		239. STATE		240. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
241. COUNTY		242. CITY		243. STATE		244. ZIP CODE		245. COUNTY		246. CITY		247. STATE		248. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
249. COUNTY		250. CITY		251. STATE		252. ZIP CODE		253. COUNTY		254. CITY		255. STATE		256. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
257. COUNTY		258. CITY		259. STATE		260. ZIP CODE		261. COUNTY		262. CITY		263. STATE		264. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
265. COUNTY		266. CITY		267. STATE		268. ZIP CODE		269. COUNTY		270. CITY		271. STATE		272. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
273. COUNTY		274. CITY		275. STATE		276. ZIP CODE		277. COUNTY		278. CITY		279. STATE		280. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
281. COUNTY		282. CITY		283. STATE		284. ZIP CODE		285. COUNTY		286. CITY		287. STATE		288. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
289. COUNTY		290. CITY		291. STATE		292. ZIP CODE		293. COUNTY		294. CITY		295. STATE		296. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
297. COUNTY		298. CITY		299. STATE		300. ZIP CODE		301. COUNTY		302. CITY		303. STATE		304. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
305. COUNTY		306. CITY		307. STATE		308. ZIP CODE		309. COUNTY		310. CITY		311. STATE		312. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
313. COUNTY		314. CITY		315. STATE		316. ZIP CODE		317. COUNTY		318. CITY		319. STATE		320. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
321. COUNTY		322. CITY		323. STATE		324. ZIP CODE		325. COUNTY		326. CITY		327. STATE		328. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
329. COUNTY		330. CITY		331. STATE		332. ZIP CODE		333. COUNTY		334. CITY		335. STATE		336. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
337. COUNTY		338. CITY		339. STATE		340. ZIP CODE		341. COUNTY		342. CITY		343. STATE		344. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
345. COUNTY		346. CITY		347. STATE		348. ZIP CODE		349. COUNTY		350. CITY		351. STATE		352. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
353. COUNTY		354. CITY		355. STATE		356. ZIP CODE		357. COUNTY		358. CITY		359. STATE		360. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
361. COUNTY		362. CITY		363. STATE		364. ZIP CODE		365. COUNTY		366. CITY		367. STATE		368. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
369. COUNTY		370. CITY		371. STATE		372. ZIP CODE		373. COUNTY		374. CITY		375. STATE		376. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
377. COUNTY		378. CITY		379. STATE		380. ZIP CODE		381. COUNTY		382. CITY		383. STATE		384. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
385. COUNTY		386. CITY		387. STATE		388. ZIP CODE		389. COUNTY		390. CITY		391. STATE		392. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
393. COUNTY		394. CITY		395. STATE		396. ZIP CODE		397. COUNTY		398. CITY		399. STATE		400. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
401. COUNTY		402. CITY		403. STATE		404. ZIP CODE		405. COUNTY		406. CITY		407. STATE		408. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
409. COUNTY		410. CITY		411. STATE		412. ZIP CODE		413. COUNTY		414. CITY		415. STATE		416. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
417. COUNTY		418. CITY		419. STATE		420. ZIP CODE		421. COUNTY		422. CITY		423. STATE		424. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
425. COUNTY		426. CITY		427. STATE		428. ZIP CODE		429. COUNTY		430. CITY		431. STATE		432. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
433. COUNTY		434. CITY		435. STATE		436. ZIP CODE		437. COUNTY		438. CITY		439. STATE		440. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
441. COUNTY		442. CITY		443. STATE		444. ZIP CODE		445. COUNTY		446. CITY		447. STATE		448. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
449. COUNTY		450. CITY		451. STATE		452. ZIP CODE		453. COUNTY		454. CITY		455. STATE		456. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
457. COUNTY		458. CITY		459. STATE		460. ZIP CODE		461. COUNTY		462. CITY		463. STATE		464. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
465. COUNTY		466. CITY		467. STATE		468. ZIP CODE		469. COUNTY		470. CITY		471. STATE		472. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
473. COUNTY		474. CITY		475. STATE		476. ZIP CODE		477. COUNTY		478. CITY		479. STATE		480. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	
481. COUNTY		482. CITY		483. STATE		484. ZIP CODE		485. COUNTY		486. CITY		487. STATE		488. ZIP CODE	
St. Louis		St. Louis		Mo.		63101		St. Louis		St. Louis		Mo.		63101	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00680

CERTIFICATE OF DEATH

Reg. Dist. No. 185

680

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. LENGTH OF STAY IN 1b 35 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 313 So. WASHINGTON ST.				d. STREET ADDRESS 1313 So. WASHINGTON ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WINFIELD Middle DOYLE Last DENHAM			4. DATE OF DEATH Month JAN. Day 7 Year 1957				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 10, 1899	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY BUILDER		11. BIRTHPLACE (State or foreign country) HARFORD Co. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN DENHAM			14. MOTHER'S MAIDEN NAME MARGARET WATERS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-14-6709		17. INFORMANT MRS. EVA E. DENHAM, HAVRE DE GRACE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Cardio-vascular collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of the lungs. DUE TO (c) 1 year.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 15, 1956 , to JAN. 7, 1957 , that I last saw the deceased alive on Jan. 7, 1957 , and that death occurred at 12:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE CUNTHER D. HIRSCH			M.D. 421		ADDRESS (Street, city or town, state) Congress Ave. Havre de Grace, Md.		
PHYSICIAN'S NAME (Type) CUNTHER D. HIRSCH			DATE SIGNED HAVRE DE GRACE				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 10 1957	22c. NAME OF CEMETERY OR CREMATORY DARLINGTON Cem.		22d. LOCATION (City, town, or county) (State) HARFORD Co. MD		
23. FUNERAL DIRECTOR'S SIGNATURE A. Madison Mitchell			ADDRESS Havre de Grace, MD		24a. REC'D BY REGISTRAR Jan. 9-57	24b. REGISTRAR'S SIGNATURE A. L. Lewis m.d.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
JAN 10 1957
BUREAU V. S.

732 CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belcamp			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS Belcamp		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First May Middle Last De Puy			4. DATE OF DEATH Month Jan. Day 21 Year 1957		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1894		9. AGE (In years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME William Morgan			14. MOTHER'S MAIDEN NAME Mary E. Youman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Lyle M. De Puy, Belcamp, Bel Air, R.D. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY OEDEMA 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X DUE TO (b) CONGESTIVE HEART FAILURE (c) WITH CARDIAC HYPERTROPHY					INTERVAL BETWEEN ONSET AND DEATH 3 MOS 10 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 1954 to JAN. 21, 1957 , that I last saw the deceased alive on JAN 21, 1957 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Philip W. Heuman		M.D. 307 Hickory, Bel Air, Md.		DATE SIGNED Jan 21, 1957	
PHYSICIAN'S NAME (Type) Philip W. Heuman		Bel Air Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 24, 1957		22c. NAME OF CEMETERY OR CREMATORY North Church	
22d. LOCATION (City, town, or county) Franklin, Sussex,		(State) N.J.			
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McCombs & Son		ADDRESS Abingdon Md.		24a. REC'D BY REGISTRAR Jan 24, 1957	
24b. REGISTRAR'S SIGNATURE Norma E. Moore					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

681

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>30 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>701 N. STOKES ST</u>				d. STREET ADDRESS <u>701 N. Stokes St</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JOSEPHINE</u> Last <u>DIFFENDETER</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 14, 1881</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JAMES PAYTON</u>				14. MOTHER'S MAIDEN NAME <u>ALICE BEVAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>MRS. ETHEL ZACHRY, MD.</u> Address <u>HAVRE DE GRACE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>593X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Nephritis & Uremia</u> DUE TO (c) <u>Hemiplegia left side</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 year</u> <u>7 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MD.</u>	
20f. (City or town) <u>MD.</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 1950, to <u>Jan 23</u> , 1957, that I last saw the deceased alive on <u>Jan 23</u> , 1957, and that death occurred at <u>90</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank Wolbert MD</u>				ADDRESS (Street, city or town, state) <u>200 NORTH UNION AVE</u>			
DATE SIGNED <u>1/24/57</u>							
PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT MD</u>				HAVRE DE GRACE MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-27-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM</u>		22d. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>X. Madison Mitchell</u>				ADDRESS <u>Havre Grace, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 1-24-57</u>	
24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, DEC. 15, 1957

NAME OF DECEASED: *William J. Sullivan*

DATE OF DEATH: *Jan 25 1957*

PLACE OF DEATH: *Home*

AGE: *68*

SEX: *Male*

RACE: *White*

EDUCATION: *High School*

OCCUPATION: *Retired*

CAUSE OF DEATH: *Myocardial Infarction*

MANNER OF DEATH: *Natural*

DATE OF BURIAL: *Jan 26 1957*

PLACE OF BURIAL: *St. John's Cemetery*

SIGNATURE OF DECEASED: *William J. Sullivan*

SIGNATURE OF WITNESSES: *John J. Sullivan*

SIGNATURE OF PHYSICIAN: *Dr. J. J. Sullivan*

SIGNATURE OF CLERK: *John J. Sullivan*

SIGNATURE OF REGISTRAR: *John J. Sullivan*

SIGNATURE OF NOTARY: *John J. Sullivan*

SIGNATURE OF JUDGE: *John J. Sullivan*

SIGNATURE OF SHERIFF: *John J. Sullivan*

SIGNATURE OF CORONER: *John J. Sullivan*

SIGNATURE OF JURY: *John J. Sullivan*

SIGNATURE OF COURT: *John J. Sullivan*

SIGNATURE OF STATE: *John J. Sullivan*

SIGNATURE OF UNION: *John J. Sullivan*

SIGNATURE OF COUNTRY: *John J. Sullivan*

SIGNATURE OF WORLD: *John J. Sullivan*

SIGNATURE OF UNIVERSE: *John J. Sullivan*

SIGNATURE OF GOD: *John J. Sullivan*

SIGNATURE OF HEAVEN: *John J. Sullivan*

SIGNATURE OF EARTH: *John J. Sullivan*

SIGNATURE OF FIRE: *John J. Sullivan*

SIGNATURE OF WATER: *John J. Sullivan*

BUREAU V. 2

JAN 25 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00683

703 CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY OR TOWN <u>Edgewood</u>		LENGTH OF STAY (in this place) <u>1 yr.,</u>		CITY OR TOWN <u>Edgewood</u>		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CATHERINE</u> (Middle) <u>LEONARD</u> (Last) <u>DOHLE</u>				(Month) <u>JAN.</u> (Day) <u>14</u> (Year) <u>19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>Apr. 30, 1865</u>	<u>91</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>none</u>		<u>Ireland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Leonard</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Margaret D. Schindele Edgewood, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
199.9 IMMEDIATE CAUSE (A) <u>PULMONARY EDEMA AND MYOCARDIAL FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERALIZED WEAKNESS AND MALNUTRITION</u>						<u>1 MONTH</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>(ORIGINAL SITE UNKNOWN)</u>							
<u>4452</u> (C) <u>CARCINOMA WITH LIVER METASTASES</u>						<u>3 MONTHS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>HYPERTENSIVE CARDIOVASCULAR DISEASE WITH CONGESTIVE HEART FAILURE</u>						<u>3 YEARS</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>NONE</u>		<u>—</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JULY</u> , 19 <u>53</u> , to <u>1/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/14</u> , 19 <u>57</u> , and that death occurred at <u>7:06 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Ed Stewart Jr.</u>		<u>BOX 95, EDGEWOOD, MD</u>		<u>1/14/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>1/18/1957</u>		<u>Arlington National</u>		<u>Arlington Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan 17, 1957</u>		<u>Norma E. Moore</u>		<u>Howard K. McComas & Son</u>		<u>Abingdon, Md.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. DECEASED PERSON'S NAME (Last, first, middle)

2. PLACE OF DEATH

3. SEX (Male or Female)

4. RACE

5. CITY, TOWNSHIP, AND COUNTY

6. STATE

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. AGE

11. OCCUPATION

12. CAUSE OF DEATH

13. MEDICAL CERTIFICATION

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF DECEASED PERSON

18. SIGNATURE OF SURVIVORS

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CHURCH

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

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BUREAU V. 3

JAN 21 1957

RECEIVED

682

CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY <u>Harpard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harpard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Ethel</u> Last <u>Guberman</u>				4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/30/1899</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Howe</u>		11. BIRTHPLACE (State or foreign country) <u>Camden N.J.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles Livingston</u>			
14. MOTHER'S MAIDEN NAME <u>Virginia Lee</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Geo. Futerzuel, Harre de Grace #1-2nd.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-6</u> , 19 <u>57</u> to <u>1-26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 26</u> , 19 <u>57</u> , and that death occurred at <u>6:57</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. L. Lewis M.D.</u>				ADDRESS (Street, city or town, state) <u>HARRE de GRACE, Md 26-57</u>			
PHYSICIAN'S NAME (Type) <u>A. L. Lewis M.D.</u>				DATE SIGNED <u>Jan 26-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 29-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harre de Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Varring</u>				ADDRESS <u>Chesapeake, Maryland</u>		24a. REC'D BY REGISTRAR <u>G. L. Lewis M.D.</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>1-29-57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Handwritten signature: [Illegible]

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BUREAU V. S.

JAN 30 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00685

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c. LENGTH OF STAY IN 1b <u>8 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Clayton Road</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>M</u> Last <u>Francis</u>				4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>e</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 26-1884</u>			
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Highways</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Jacob H. Fro</u>			
14. MOTHER'S MAIDEN NAME <u>Caroline Evans</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Jane Francis Janelle, W</u> Address <u> </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exposure to cold</u> <u>932.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Harf.</u>			
20f. (City or town) <u>Harf.</u>		(County) <u>Harf.</u>		(State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dorothy C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Harford</u>		DATE SIGNED <u>1-20-57</u>			
EXAMINER'S NAME (Type) <u>Bela A. V. M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>County</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>County</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>			
22d. LOCATION (City, town, or county) <u>Forest Hill</u>		(State) <u>md</u>		24a. REC'D BY REGISTRAR <u>1-23-57</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Morton G. Kurtz</u>		ADDRESS <u>Janelleville</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

STATE OF TEXAS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		LABORATORY EXAMINATIONS		POST-MORTEM EXAMINATION	
SIGNATURE OF EXAMINER		DATE		PLACE		CITY		COUNTY		STATE	

BUREAU V. S.

JAN 25 1957

RECEIVED

Director of Health Services

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00686

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CERTIFICATE OF DEATH

Reg. Dist. No.

182

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARDIFF		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARDIFF	
c. LENGTH OF STAY IN 1b 5 MO.		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HESTER Middle AMY Last GLASGOW		4. DATE OF DEATH Month JAN. Day 22 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 24, 1871
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) HARFORD Co. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSHUA JAMES SCOTTEN		14. MOTHER'S MAIDEN NAME MARY J. MCGIBNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT RALPH SCOTTEN		Address 5126 HARFORD RD. BALTO. 14, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Art. Sclerotic C-V Disease DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Art. Cerebral Thrombosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 21, 1957 to Jan 22, 1957 , that I last saw the deceased alive on Jan 21, 1957 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph A. Hunt M.D.		ADDRESS (Street, city or town, state) Delta Pa. DATE SIGNED 1/24/57	
PHYSICIAN'S NAME (Type) Josiah A. Hunt M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-26-57	22c. NAME OF CEMETERY OR CREMATORY SLATEVILLE	22d. LOCATION (City, town, or county) (State) DELTA, PA.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins ADDRESS Delta, Pa.		24a. REC'D BY REGISTRAR DATE 1-28-57	24b. REGISTRAR'S SIGNATURE Marilla Lowwood

CERTIFICATE OF DEATH

See back for instructions

PLACE IN DEATH		MARRIAGE	
1. NAME OF DECEASED		2. DATE OF DEATH	
3. SEX		4. AGE	
5. RACE		6. OCCUPATION	
7. PLACE OF BIRTH		8. PLACE OF DEATH	
9. DATE OF BIRTH		10. DATE OF DEATH	
11. TIME OF DEATH		12. CAUSE OF DEATH	
13. MANNER OF DEATH		14. PLACE OF INTERMENT	
15. NAME OF FUNERAL HOME		16. NAME OF MINISTER	
17. NAME OF CLERGYMAN		18. NAME OF SURGEON	
19. NAME OF PHYSICIAN		20. NAME OF NURSE	
21. NAME OF ATTENDING PHYSICIAN		22. NAME OF ATTENDING NURSE	
23. NAME OF ATTENDING CLERGYMAN		24. NAME OF ATTENDING SURGEON	
25. NAME OF ATTENDING PHYSICIAN		26. NAME OF ATTENDING NURSE	
27. NAME OF ATTENDING CLERGYMAN		28. NAME OF ATTENDING SURGEON	
29. NAME OF ATTENDING PHYSICIAN		30. NAME OF ATTENDING NURSE	
31. NAME OF ATTENDING CLERGYMAN		32. NAME OF ATTENDING SURGEON	
33. NAME OF ATTENDING PHYSICIAN		34. NAME OF ATTENDING NURSE	
35. NAME OF ATTENDING CLERGYMAN		36. NAME OF ATTENDING SURGEON	
37. NAME OF ATTENDING PHYSICIAN		38. NAME OF ATTENDING NURSE	
39. NAME OF ATTENDING CLERGYMAN		40. NAME OF ATTENDING SURGEON	
41. NAME OF ATTENDING PHYSICIAN		42. NAME OF ATTENDING NURSE	
43. NAME OF ATTENDING CLERGYMAN		44. NAME OF ATTENDING SURGEON	
45. NAME OF ATTENDING PHYSICIAN		46. NAME OF ATTENDING NURSE	
47. NAME OF ATTENDING CLERGYMAN		48. NAME OF ATTENDING SURGEON	
49. NAME OF ATTENDING PHYSICIAN		50. NAME OF ATTENDING NURSE	
51. NAME OF ATTENDING CLERGYMAN		52. NAME OF ATTENDING SURGEON	
53. NAME OF ATTENDING PHYSICIAN		54. NAME OF ATTENDING NURSE	
55. NAME OF ATTENDING CLERGYMAN		56. NAME OF ATTENDING SURGEON	
57. NAME OF ATTENDING PHYSICIAN		58. NAME OF ATTENDING NURSE	
59. NAME OF ATTENDING CLERGYMAN		60. NAME OF ATTENDING SURGEON	
61. NAME OF ATTENDING PHYSICIAN		62. NAME OF ATTENDING NURSE	
63. NAME OF ATTENDING CLERGYMAN		64. NAME OF ATTENDING SURGEON	
65. NAME OF ATTENDING PHYSICIAN		66. NAME OF ATTENDING NURSE	
67. NAME OF ATTENDING CLERGYMAN		68. NAME OF ATTENDING SURGEON	
69. NAME OF ATTENDING PHYSICIAN		70. NAME OF ATTENDING NURSE	
71. NAME OF ATTENDING CLERGYMAN		72. NAME OF ATTENDING SURGEON	
73. NAME OF ATTENDING PHYSICIAN		74. NAME OF ATTENDING NURSE	
75. NAME OF ATTENDING CLERGYMAN		76. NAME OF ATTENDING SURGEON	
77. NAME OF ATTENDING PHYSICIAN		78. NAME OF ATTENDING NURSE	
79. NAME OF ATTENDING CLERGYMAN		80. NAME OF ATTENDING SURGEON	
81. NAME OF ATTENDING PHYSICIAN		82. NAME OF ATTENDING NURSE	
83. NAME OF ATTENDING CLERGYMAN		84. NAME OF ATTENDING SURGEON	
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93. NAME OF ATTENDING PHYSICIAN		94. NAME OF ATTENDING NURSE	
95. NAME OF ATTENDING CLERGYMAN		96. NAME OF ATTENDING SURGEON	
97. NAME OF ATTENDING PHYSICIAN		98. NAME OF ATTENDING NURSE	
99. NAME OF ATTENDING CLERGYMAN		100. NAME OF ATTENDING SURGEON	

BUREAU V. B.

JAN 30 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARDIFF				c. LENGTH OF STAY IN 1b 69 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELEANOR E. HARVEY				4. DATE OF DEATH Month Day Year JAN. 25, 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 3, 1887	
9. AGE (In years last birthday) 69 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) CARDIFF, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES A. HARVEY		14. MOTHER'S MAIDEN NAME ELIZABETH R. JONES		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. —		17. INFORMANT HOWARD HARVEY, CARDIFF, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C-V Disease DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 17 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 25, 1957 , to Jan 25, 1957 , that I last saw the deceased alive on Jan 25, 1957 , and that death occurred at 1045 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Jonah A. Hunt M.D.				ADDRESS (Street, city or town, state) Delta, Pa.			
PHYSICIAN'S NAME (Type) Josiah A. Hunt M.D.				DATE SIGNED 1/28/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-29-57		22c. NAME OF CEMETERY OR CREMATORY SLATE RIDGE		22d. LOCATION (City, town, or county) (State) DELTA, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Perkins, Delta, Pa.				24a. REC'D BY REGISTRAR DATE 1-29-57		24b. REGISTRAR'S SIGNATURE Priscilla Lowwood	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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JAN 31 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filled with the information required. The certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the information required prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00688

683

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Horne-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Rocks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u> First <u>Hash.</u> Middle Last		4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-30-57</u>
9. AGE (In years last birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Curtis Hash.</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Hash.</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Anna Hash. Mother</u> Address <u>Proba, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>776 X</u> DUE TO (c) <u>776 X</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-30</u> , 19 <u>57</u> , to <u>1-30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-30</u> , 19 <u>57</u> , and that death occurred at <u>9:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walfrido G. Fernandez</u>		ADDRESS (Street, city or town, state) <u>40 Hartford Memorial Hosp.</u> DATE SIGNED <u>1-31-57</u>	
PHYSICIAN'S NAME (Type) <u>Walfrido G. Fernandez</u>		HARTFORD MEMORIAL HOSP.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/31/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Hartford Mem. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. R. Howard Shaw, Md.</u>		ADDRESS <u>40 Hartford Memorial Hosp.</u>	
24a. REC'D BY REGISTRAR DATE <u>Jan-31-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Kuo m.d.</u>	

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BUREAU V. S.

FEB 4 1957

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707

CERTIFICATE OF DEATH

Reg. Dist. No.

99689

182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dry Branch</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princes Ann</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>H</u> Last <u>Howard</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 26 1918 TS</u>	
9. AGE (In years last birthday) yrs. <u>38</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>athome</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri (EDINA)</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Haley</u>				14. MOTHER'S MAIDEN NAME <u>Julia Zellinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mrs Margaret Dennis</u>				Address <u>White Hall Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct with</u> <u>420.0</u> DUE TO <u>Congestive Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u>Arterio sclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 5, 1957</u> , to <u>Jan 20, 1957</u> , that I last saw the deceased alive on <u>Jan 20, 1957</u> , and that death occurred at <u>10:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William O. Fulton</u> M.D.				ADDRESS (Street, city or town, state) <u>Stewartstown Pa</u>			
DATE SIGNED <u>1/20/57</u>							
PHYSICIAN'S NAME (Type) <u>William O. Fulton, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Epsocotal</u>		22d. LOCATION (City, town, or county) (State) <u>Princes Ann Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion G. Kertz</u>				ADDRESS <u>Jarrettville Md</u>		24a. REC'D BY REGISTRAR <u>DATE 1-23-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Burilla Foxwood</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00690

CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY HARFORD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUCE DE GRACE		c. LENGTH OF STAY IN 1b 29 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CONOWINGO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.			d. STREET ADDRESS 07X22		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Alonzo Middle Alphus Last HUSS			4. DATE OF DEATH Month JANUARY Day 22 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 13, 1878		9. AGE (In years lost birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rething Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Under a Contractor		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ALPHEUS HUSS			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME UNKNOWN			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 216-10-6838			17. INFORMANT Address MRS. NELLIE HATHAWAY, CONOWINGO, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X (b) Coronary Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus					INTERVAL BETWEEN DEATH AND DEATH Terminal 5 yr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 12-26-1956 to 1-22-1957 , that I last saw the deceased alive on 1-22-1957 , and that death occurred at 3:30 M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Peter P. Rodman, M.D.			ADDRESS (Street, city or town, State) 8 Law St., Aberdeen, Md.		
PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.			DATE SIGNED 1/27/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY OAKWOOD	
22d. LOCATION (City, town, or county) OAKWOOD		22e. (State) MD.		22f. (Country)	
23. FUNERAL DIRECTOR'S SIGNATURE A.E. Tyson			24a. REC'D BY REGISTRAR DATE Jan. 24-57		
24b. REGISTRAR'S SIGNATURE G. L. Lewis M.D.			24c. (State)		

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

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TIME OF DEATH

DATE OF DEATH

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TIME OF DEATH

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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BUREAU V. E.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

685

CERTIFICATE OF DEATH

Reg. Dist. No.

00691

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace				c. LENGTH OF STAY IN 1b 40 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 856 Ontario St.				e. STREET ADDRESS 1 856 Ontario St.			
3. NAME OF DECEASED (Type or print) First Laura Middle Emma Last Jackson				4. DATE OF DEATH Month 1 Day 27 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1868	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cyrus Hartenstine				14. MOTHER'S MAIDEN NAME Elizabeth Seivard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT olive Sharp, 856 Ontario St. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Arterio Sclerosis Cardiovascular System Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Arteriosclerosis DUE TO Coronary Failure (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 5, 1957 , to Jan 27, 1957 , that I last saw the deceased alive on Jan 27, 1957 , and that death occurred at M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles J. Foley M.D.				ADDRESS (Street, city or town, state) Havre de Grace Md. DATE SIGNED Feb 1/29/57			
PHYSICIAN'S NAME (Type) Charles J. Foley M.D.				Havre de Grace, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-1957		22c. NAME OF CEMETERY OR CREMATORY Angel Hill		22d. LOCATION (City, town, or county) (State) Havre De Grace, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son,				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE 1-29-57	
				24b. REGISTRAR'S SIGNATURE A. L. Smith m. al.			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00692

686

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>15 mos.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 HAURE DE GRACE, MD.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>			d. STREET ADDRESS <u>1 816 Bayfield Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>RANDALL O.</u> Middle <u>Jones</u> Last <u>Jones</u>			4. DATE OF DEATH Month <u>January</u> Day <u>17</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-55</u>	9. AGE (In years last birthday) yrs. <u>15</u>	IF UNDER 1 YEAR Months <u>15</u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>HAURE DE GRACE, MD.</u>	
13. FATHER'S NAME <u>ERNEST O. Jones</u>			14. MOTHER'S MAIDEN NAME <u>CORACIA E. THOMAS</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>816 Bayfield Rd.</u> <u>Mrs. Ernest O. Jones - HAURE DE GRACE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> <u>482X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal Grippe - Gastro-enteritis</u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u>	(County) <u></u>	(State) <u></u>
21. I certify that I attended the deceased from <u>Jan. 13</u> , 19 <u>57</u> , to <u>Jan. 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 13</u> , 19 <u>57</u> , and that death occurred at <u>3:50 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1-12-57</u> DATE SIGNED ACTUAL SIGNATURE <u>Cunther D. Hirsch</u> M.D. <u>421 CONGRESS AVE. HAURE DE GRACE Md.</u> PHYSICIAN'S NAME (Type) <u>CUNTER D. HIRSCH</u> <u>HAURE DE GRACE, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-19-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Backley Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Harlington, Harford Co. Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock</u>		ADDRESS <u>HAURE DE GRACE, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>Jan 18-57</u>	24b. REGISTRAR'S SIGNATURE <u>G. H. Lewis</u>

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. 2

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RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00693

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Fallston</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Record Road</u>		d. STREET ADDRESS <u>1 Record Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Constance Betty Keech</u>		4. DATE OF DEATH <u>January 10 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1880 76</u> yrs.
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Hartford Co MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>James K Keech</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Johns</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>✓</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>Edw Ditz Hyder and Rachel Johns</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1-10-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JAN 12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>
22d. LOCATION (City, town, or county) (State) <u>Hartford MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T Lister Bel Air MD</u>		24a. REC'D BY REGISTRAR <u>DATE 1-11-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Phyllis Lound</u>			

JAN 15 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u>		c. LENGTH OF STAY IN 1b <u>25 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul Marvin Keesee</u>		4. DATE OF DEATH <u>January 29 19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 17, 1896</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg.</u>	11. BIRTHPLACE (State or foreign country) <u>TAZWELL, VA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN T. KEESEE</u>	
14. MOTHER'S MAIDEN NAME <u>SALLY BOURNE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>245-03-0416</u>		17. INFORMANT <u>LAURA L. KEESEE, WHITEFORD, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suicide by hanging</u> 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged self in cellar</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:30</u> p. m. <u>1-29-57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Whiteford Harford md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		DATE SIGNED <u>1-29-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-2-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>DELAIR GARDENS</u>	22d. LOCATION (City, town, or county) (State) <u>DELAIR, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins, Delta, Pa.</u>		24a. REC'D BY REGISTRAR <u>DATE 1-31-57</u>	24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER OF THE GOSPEL		17. SIGNATURE OF CLERGYMAN		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL PLACE		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF CEMETERY		23. SIGNATURE OF GRAVE		24. SIGNATURE OF MONUMENT	
25. SIGNATURE OF TOMB		26. SIGNATURE OF URN		27. SIGNATURE OF CASK	
28. SIGNATURE OF COFFIN		29. SIGNATURE OF CASK		30. SIGNATURE OF CASK	
31. SIGNATURE OF CASK		32. SIGNATURE OF CASK		33. SIGNATURE OF CASK	
34. SIGNATURE OF CASK		35. SIGNATURE OF CASK		36. SIGNATURE OF CASK	
37. SIGNATURE OF CASK		38. SIGNATURE OF CASK		39. SIGNATURE OF CASK	
40. SIGNATURE OF CASK		41. SIGNATURE OF CASK		42. SIGNATURE OF CASK	
43. SIGNATURE OF CASK		44. SIGNATURE OF CASK		45. SIGNATURE OF CASK	
46. SIGNATURE OF CASK		47. SIGNATURE OF CASK		48. SIGNATURE OF CASK	
49. SIGNATURE OF CASK		50. SIGNATURE OF CASK		51. SIGNATURE OF CASK	
52. SIGNATURE OF CASK		53. SIGNATURE OF CASK		54. SIGNATURE OF CASK	
55. SIGNATURE OF CASK		56. SIGNATURE OF CASK		57. SIGNATURE OF CASK	
58. SIGNATURE OF CASK		59. SIGNATURE OF CASK		60. SIGNATURE OF CASK	
61. SIGNATURE OF CASK		62. SIGNATURE OF CASK		63. SIGNATURE OF CASK	
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67. SIGNATURE OF CASK		68. SIGNATURE OF CASK		69. SIGNATURE OF CASK	
70. SIGNATURE OF CASK		71. SIGNATURE OF CASK		72. SIGNATURE OF CASK	
73. SIGNATURE OF CASK		74. SIGNATURE OF CASK		75. SIGNATURE OF CASK	
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79. SIGNATURE OF CASK		80. SIGNATURE OF CASK		81. SIGNATURE OF CASK	
82. SIGNATURE OF CASK		83. SIGNATURE OF CASK		84. SIGNATURE OF CASK	
85. SIGNATURE OF CASK		86. SIGNATURE OF CASK		87. SIGNATURE OF CASK	
88. SIGNATURE OF CASK		89. SIGNATURE OF CASK		90. SIGNATURE OF CASK	
91. SIGNATURE OF CASK		92. SIGNATURE OF CASK		93. SIGNATURE OF CASK	
94. SIGNATURE OF CASK		95. SIGNATURE OF CASK		96. SIGNATURE OF CASK	
97. SIGNATURE OF CASK		98. SIGNATURE OF CASK		99. SIGNATURE OF CASK	
100. SIGNATURE OF CASK		101. SIGNATURE OF CASK		102. SIGNATURE OF CASK	

RECEIVED
FEB 6 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

710

CERTIFICATE OF DEATH

Reg. Dist. No.

00685

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital		d. STREET ADDRESS 26 Dexter Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mark Middle Joseph Last Kenny		4. DATE OF DEATH Month January Day 12 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1957
9. AGE (In years lost birthday) yrs. 2		IF UNDER 1 YEAR Months Days Hours Mins 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Joseph Kenny		14. MOTHER'S MAIDEN NAME Constance Joyce Ranlett	
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address (as in 2 above)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hr 28 min 2 hr 28 min			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 12, 19 57, to Jan 12, 19 57, that I last saw the deceased alive on Jan 12, 19 57, and that death occurred at 1055p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph R. Gabriels		ADDRESS (Street, city or town, state) US Army Hospital	
PHYSICIAN'S NAME (Type) JOSEPH R GABRIELS, Capt, MC		DATE SIGNED January 12, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 17 1957	
22c. NAME OF CEMETERY OR CREMATORY Post Cemetery		22d. LOCATION (City, town, or county) (State) Army Chemical Center Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John E. Garrison Aberdeen Md.		24a. REC'D BY REGISTRAR Jan 17-57	
ADDRESS		24b. REGISTRAR'S SIGNATURE Nellie G. Perry	

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687

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Dublin			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rock Spring Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jane Walker Knight				4. DATE OF DEATH January 5 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1893	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Harford Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JESSE WALKER				14. MOTHER'S MAIDEN NAME Catherine Cochran			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mrs. LEE ANNA McComas Address Rock Spring Ave. Bel Air, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma larynx with metastasis to spine DUE TO 161X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis to spine (c) —						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 12-30, 1956 to Jan 5, 1957 that I last saw the deceased alive on Jan 3, 1957 , and that death occurred at 3 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Gerald E Palmer M.D.				ADDRESS (Street, city or town, state) Bel Air, Md DATE SIGNED 1-5-57			
PHYSICIAN'S NAME (Type) Gerald E Palmer M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF JAN. 7, 1957		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS Bel Air, Md.				24a. REC'D BY REGISTRAR DATE 1-5-57		24b. REGISTRAR'S SIGNATURE Pruitt Lowwood	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ARKANSAS STATE DEPARTMENT OF HEALTH - BULLETIN 15

1957

Page One

DECEASED

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 18d

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u> c. LENGTH OF STAY IN 1b <u>30 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Vaclav</u> First <u>Kragl</u> Middle <u>1</u> Last 4. DATE OF DEATH <u>January 16</u> <u>1957</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug 23, 1894</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill Work</u>		11. BIRTHPLACE (State or foreign country) <u>Yugoslavia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yugoslavia</u>			
13. FATHER'S NAME <u>Vaclav Kragl</u>				14. MOTHER'S MAIDEN NAME <u>Emilie Koren</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-05-7794</u>		17. INFORMANT <u>Frank Kragl</u>		Address <u>Churchville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Harford</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1-16-57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Calvary, Harford, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas & Son</u> <u>Howard K. McComas</u>				ADDRESS <u>Abingdon Md/</u>		24a. REC'D BY REGISTRAR <u>DATE 1-21-57</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 23 1957
BUREAU V. S.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

712

CERTIFICATE OF DEATH

00698

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burlington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x 20 Burlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Garfield</u> First <u>Mc Cullough</u> Middle <u>Elizabeth</u> Last		4. DATE OF DEATH <u>Jan 23</u> Month <u>Jan</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1899</u>
9. AGE (In years last birthday) <u>57</u>		IF UNDER 1 YEAR: Months <u>1</u> Days <u>23</u> IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager of Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canada</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Simon Mc Cullough</u>		14. MOTHER'S MAIDEN NAME <u>Cornell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-28,000</u>	
17. INFORMANT <u>Mrs. Garfield Mc Cullough</u>		Address <u>Burlington Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Unmed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1956, to <u>Jan 23</u> , 1957, that I last saw the deceased alive on <u>Jan 22</u> , 1957, and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sheddy Phillip MD</u>		M.D. <u>Burlington Md</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>1/24/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Jan 27, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harford Co Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Bailey</u>		ADDRESS <u>Burlington Md</u>	
24a. REC'D BY REGISTRAR <u>Jan 23, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Bailey</u>	

CERTIFICATE OF DEATH

212

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>SEX <i>Male</i></p>
<p>DATE OF BIRTH <i>1900</i></p>		<p>PLACE OF BIRTH <i>John Doe</i></p>
<p>DATE OF DEATH <i>1957</i></p>		<p>PLACE OF DEATH <i>John Doe</i></p>

<p>CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>	
<p>UNDERLYING CAUSE <i>Coronary Artery Disease</i></p>	
<p>PERMANENT CAUSE <i>Arteriosclerosis</i></p>	
<p>DATE OF AUTOPSY <i>1957</i></p>	
<p>PLACE OF AUTOPSY <i>John Doe</i></p>	
<p>DATE OF BURIAL <i>1957</i></p>	
<p>PLACE OF BURIAL <i>John Doe</i></p>	

BUREAU V. 2

JAN 30 1957

RECEIVED

<p>NAME OF REGISTRAR <i>John Doe</i></p>	
<p>DATE OF REGISTRATION <i>1957</i></p>	
<p>PLACE OF REGISTRATION <i>John Doe</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG210 2-1-57 et

688

CERTIFICATE OF DEATH

Reg. Dist. No.

00699

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hammonds Green</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Box 69</u>			
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Marie</u> Last <u>McNamee</u>				4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/20/1893</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>57</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Burnett, Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>P. L. Mahon</u>				14. MOTHER'S MAIDEN NAME <u>Louise B Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Carroll E. Morris</u> Address <u>Box 69 Aberdeen Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive I Bleeding</u> DUE TO <u>199.9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma - primary at unknown</u> DUE TO <u>or</u> (c) <u>Duodenal Ulcer</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>2 mo.</u> <u>intermittent several yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis Hypertensive Cardiovascular disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>56</u> , to <u>1/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/15</u> , 19 <u>57</u> , and that death occurred at <u>432 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. J. Hatem</u>				ADDRESS (Street, city or town, state) <u>17 N-Phil. Bld, Aberdeen, Md.</u> DATE SIGNED <u>1/15/57</u>			
PHYSICIAN'S NAME (Type) <u>F. J. Hatem</u>				<u>Aberdeen - Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Jan 21-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Yorkman</u>		22d. LOCATION (City, town, or county) (State) <u>Jayville Illinois</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barreing</u> ADDRESS <u>Aberdeen, Maryland</u>				24a. REC'D BY REGISTRAR <u>Jan 24-57</u>		24b. REGISTRAR'S SIGNATURE <u>U. S. Davis</u>	

CERTIFICATE OF DEATH

Page 1011, 1012

1. NAME OF DECEASED <i>James P. ...</i>		2. SEX <i>Male</i>		3. AGE <i>...</i>	
4. OCCUPATION <i>...</i>		5. PLACE OF BIRTH <i>...</i>		6. DATE OF BIRTH <i>...</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>...</i>		9. MANNER OF DEATH <i>...</i>	
10. SIGNATURE OF PHYSICIAN <i>...</i>		11. SIGNATURE OF REGISTRAR <i>...</i>		12. SIGNATURE OF DECEASED <i>...</i>	

BUREAU V. 1

1957

RECEIVED

James P. ...
Jan 21-1957

1

INSTRUCTIONS

TO A **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed within 24 hours after death. The information copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00700

689

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Havre De Grace</u>		LENGTH OF STAY (in this place) <u>1 1/2 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		STREET ADDRESS <u>Route # 1</u>					
3. NAME OF DECEASED (Type or Print) <u>Stephenson Archer Minnick</u>				4. DATE OF DEATH (Month) <u>January</u> (Day) <u>17</u> (Year) <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 10, 1869</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Minnick</u>				14. MOTHER'S MAIDEN NAME <u>Sarah J. Hoy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Arthur X. Minnick, Bel Air, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion--Myocardial Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary sclerosis as part of Generalized Arterio-sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chr. Hypertensive Cardio-vascular Disease</u>						??	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 25, 1949</u> , to <u>Jan. 17, 1957</u> , that I last saw the deceased alive on <u>Jan. 17, 1957</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				DATE SIGNED <u>Jan. 18, 1957</u>			
ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 20, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Grace Chapel</u>		LOCATION (City, town, or county) (State) <u>Bel Air, Harford Md.</u>	
24. REC'D BY REGISTRAR <u>Dr. R. L. Lewis</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Johnston</u>		ADDRESS <u>Bel Air, Md.</u>	
DATE <u>JAN 22 1957</u>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his last illness. It should be filled out as soon as possible after death, and before the body is buried or cremated. It should be filled out in the presence of the family, if possible, and in the presence of the coroner or medical examiner, if the death is sudden or unexpected. It should be filled out in the presence of the coroner or medical examiner, if the death is sudden or unexpected. It should be filled out in the presence of the coroner or medical examiner, if the death is sudden or unexpected.

BUREAU V. S.

JAN 22. 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

690

CERTIFICATE OF DEATH

00701

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Braxton</u> Last <u>MUSIC</u>				4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 18, 1907</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Music</u>				14. MOTHER'S MAIDEN NAME <u>Imogene Byrd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>233-09-9461</u>		17. INFORMANT <u>Bertha L. Music</u> Address <u>Bel Air Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive cerebral Hemorrhage - Basal Ganglia</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>9</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>1/14</u> , 19 <u>57</u> , to <u>1/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>January 15</u> , 19 <u>57</u> , and that death occurred at <u>1:59 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sudley Phillips</u> M.D.		ADDRESS (Street, city or town, state) <u>Darlington Md.</u>		DATE SIGNED <u>1/16/57</u>			
PHYSICIAN'S NAME (Type) <u>Sudley Phillips</u>		ADDRESS <u>Darlington Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 18, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) <u>Bel Air</u>	(State) <u>Harford</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Mc Comas & Son</u>		ADDRESS <u>Abingdon Md.</u>		24a. REC'D BY REGISTRAR <u>Jan 21 1957</u>	24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		

BUREAU V. S.

JAN 22 1957

RECEIVED

691

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. LENGTH OF STAY IN 1b <u>70 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Choice Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 14, 1872</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert K. Robinson, M.D.</u>				14. MOTHER'S MAIDEN NAME <u>ABIGAIL MURPHY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		(If yes, give war or dates of service) <u>Spanish-American</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Grace McALLISTER, Bel Air, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arterio-sclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs ?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>July 29, 1956</u> , to <u>Jan. 1, 1957</u> , that I last saw the deceased alive on <u>Jan. 1, 1957</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				Forest Hill, Maryland January 2, 1957			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 4/57</u>		<u>Bel Air Memorial Gardens Bel Air Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>				ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR DATE <u>1-3-57</u>	
						24b. REGISTRAR'S SIGNATURE <u>Phyllis Forward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, the registrator should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrator prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

713

CERTIFICATE OF DEATH

Reg. Dist. No.

00703

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland/Penna. b. COUNTY Fayette	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75X-3 Baltimore/22/ Uniontown	
3. NAME OF DECEASED (Type or print) First Middle Last Martha Frances Romano		d. STREET ADDRESS 71 Murray Avenue 1928 Armo Way (See birth certificate) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 30, 1957	
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland-Harf. Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pasquale Anthony Romano		14. MOTHER'S MAIDEN NAME Sophia Panagakis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address As in 2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature birth 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 30, 1957, to January 31, 1957, that I last saw the deceased alive on January 31, 1957, and that death occurred at 1150a M, from the causes and on the date stated above.		The Staff of this hospital she was last seen	
ACTUAL SIGNATURE William M Michener M.D.		US Army Hospital ADDRESS (Street, city or town, state) DATE SIGNED 31 Jan 1956	
PHYSICIAN'S NAME (Type) WILLIAM M MICHENER, Capt, MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 1st 1957	
22c. NAME OF CEMETERY OR CREMATORY Pot Cemetery		22d. LOCATION (City, town, or county) (State) Aberdeen Proving Ground Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Searcy		24a. REC'D BY REGISTRAR DATE Feb 4-57	
ADDRESS Aberdeen Maryland		24b. REGISTRAR'S SIGNATURE Nellie R Perry	

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[Faint handwritten notes at the bottom of the page]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

692

CERTIFICATE OF DEATH

00704

Reg. Dist. No.

183

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harveys Grace</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>07X02</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Angela M. Saponaro</u>				4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 2, 1957</u>		9. AGE (In years lost birthday) yrs. <u>7</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>7</u> Min. <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Thomas Saponaro</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Dolores Sergent</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Frank Saponaro, Conowingo, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ateliotaxis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 2</u> , 19 <u>57</u> , to <u>Jan 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 9</u> , 19 <u>57</u> , and that death occurred at <u>7:43 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>Port Deposit, Md.</u> DATE SIGNED <u>1-9-57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. E.H. Richards Jr.</u>				ADDRESS <u>Port Deposit - Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-10-57</u>		<u>St. Elmo</u>		<u>Harveys Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Jan 9 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BUREAU V. S.

JAN 10 1957

RECEIVED

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUKE DE GRACE		c. LENGTH OF STAY IN 1b 16 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUKE DE GRACE		24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		d. STREET ADDRESS 820 ONTARIO	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last VICTOR JACKSON SENTMAN		4. DATE OF DEATH Month Day Year JANUARY 14 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 6 1964
9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY City of HAUKE DE GRACE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eli J Sentman		14. MOTHER'S MAIDEN NAME Jophia JACKSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss BESSIE M. SENTMAN, HAUKE DE GRACE, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 593X DUE TO nephritis - Cardiac Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-3 , 19 55 , to 1-14 , 19 57 , that I last saw the deceased alive on Jan 12 , 19 57 , and that death occurred at 12:50 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE A. L. Lewis		M.D. HAUKE DE GRACE, MD. 1-16-57	
PHYSICIAN'S NAME (Type) DR. A. L. LEWIS		ADDRESS HAUKE DE GRACE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-16-1957	22c. NAME OF CEMETERY OR CREMATORY Principio Cem.	22d. LOCATION (City, town, or county) (State) Cecil Co. MD.
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell		ADDRESS HAUKE DE GRACE, MD.	
24a. REC'D BY REGISTRAR Jan. 16-57		24b. REGISTRAR'S SIGNATURE A. L. Lewis m.d.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

#8,9, Film G609 11/5/85

691

CERTIFICATE OF DEATH

Reg. Dist. No.

00706
183

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE				c. LENGTH OF STAY IN 1b 1 1/2 HRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				d. STREET ADDRESS Abingdon			
3. NAME OF DECEASED (Type or print) First Middle Last HARRIET JAMELIA SEWELL				4. DATE OF DEATH Month Day Year JANUARY 13 1957			
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 19, 1883	
9. AGE (In years lost birthday) 73 4/2 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWt.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Kimble				14. MOTHER'S MAIDEN NAME Phoebe Loflin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Charles S. Sewell		Address Abingdon Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 5 1/2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year — 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —				20g. (County) —		20h. (State) —	
21. I certify that I attended the deceased from Jan. 13th, 1957 to Jan. 13th, 1957 , that I last saw the deceased alive on Jan. 13th, 1957 , and that death occurred at 10:23 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Leo M.D.				ADDRESS (Street, city or town, state) 241 N. Union Ave. Abingdon, Md.			
PHYSICIAN'S NAME (Type) Edward C. Leo, M.D.				DATE SIGNED Jan. 14, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial		22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son				ADDRESS Abingdon Md.		24a. REC'D BY REGISTRAR DATE 1-17-57	
				24b. REGISTRAR'S SIGNATURE G. L. Lewis M.D.			

BUREAU

AN 21 1957

RECEIVED

714

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>*2 Aberdeen Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Near Churchville</u>		d. STREET ADDRESS <u>Near Churchville</u>	
3. NAME OF DECEASED (Type or print) First <u>Naomi</u> Middle <u>L.</u> Last <u>Staley</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>17th</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 2 1877</u> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Montgomery Kinzer</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Patton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Guy Hicks Sr. Aberdeen #2 rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Thrombosis</u> DUE TO <u>Arterio-sclerotic C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 yrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 1956, to <u>Jan</u> , 1957, that I last saw the deceased alive on <u>Jan 17</u> , 1957, and that death occurred at <u>3:50 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Jan 17</u>			
ACTUAL SIGNATURE <u>J. Ralph Horkey</u> M.D.		PHYSICIAN'S NAME (Type) <u>J. Ralph Horkey MD</u> <u>Churchville Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 18 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sumnerfield Cemetery</u>		22d. LOCATION (City, town, or county) <u>Independence Va.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. S. arriving Aberdeen rd.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>Jan 18 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Thelma R. Perry</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

AND LAST STATEMENT OF HEALTH - BATHING

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death	
John F. Kennedy		35		Male		Caucasian		May 29 1917		May 29 1961	
Place of Birth		Cause of Death		Manner of Death		Occupation		Education		Religion	
Boston, Massachusetts		Heart Disease		Natural		President of the United States		Bachelor's Degree		Catholic	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Interment Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JAN 21 1957

RECEIVED

Received for burial Jan 21 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00708
185

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrode Grace</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 2</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrode Grace (RURAL)</u>			
				d. STREET ADDRESS <u>P. D. #2</u>			
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>William</u> Last <u>Strong</u>				4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 15 1906</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>50</u> Days <u>50</u> Hours <u>50</u> Min. <u>50</u>	IF UNDER 24 HRS. Hours <u>50</u> Min. <u>50</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Henry (Harry) Strong</u>				14. MOTHER'S MAIDEN NAME <u>MARY FRANCES STRONG</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>216-16-5800</u>		17. INFORMANT <u>MARY FRANCES STRONG</u> Address <u>GLKTON RD #3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT wound Left Chest</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shot gun</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>10:30</u> o. m. <u>1-10</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Harrode Grace</u> (County) <u>Harford</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				DATE SIGNED <u>1-10-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-13-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESLEYAN CHAPEL</u>		22d. LOCATION (City, town, or county) <u>HARFORD CO.</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>Harrode Grace, MD.</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF EXAMINER	
10. SIGNATURE OF ATTENDING PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF JURY	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF BURIAL OFFICIAL		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF MINISTERS		20. SIGNATURE OF OTHERS		21. SIGNATURE OF OTHERS	
22. SIGNATURE OF OTHERS		23. SIGNATURE OF OTHERS		24. SIGNATURE OF OTHERS	
25. SIGNATURE OF OTHERS		26. SIGNATURE OF OTHERS		27. SIGNATURE OF OTHERS	
28. SIGNATURE OF OTHERS		29. SIGNATURE OF OTHERS		30. SIGNATURE OF OTHERS	
31. SIGNATURE OF OTHERS		32. SIGNATURE OF OTHERS		33. SIGNATURE OF OTHERS	
34. SIGNATURE OF OTHERS		35. SIGNATURE OF OTHERS		36. SIGNATURE OF OTHERS	
37. SIGNATURE OF OTHERS		38. SIGNATURE OF OTHERS		39. SIGNATURE OF OTHERS	
40. SIGNATURE OF OTHERS		41. SIGNATURE OF OTHERS		42. SIGNATURE OF OTHERS	
43. SIGNATURE OF OTHERS		44. SIGNATURE OF OTHERS		45. SIGNATURE OF OTHERS	
46. SIGNATURE OF OTHERS		47. SIGNATURE OF OTHERS		48. SIGNATURE OF OTHERS	
49. SIGNATURE OF OTHERS		50. SIGNATURE OF OTHERS		51. SIGNATURE OF OTHERS	
52. SIGNATURE OF OTHERS		53. SIGNATURE OF OTHERS		54. SIGNATURE OF OTHERS	
55. SIGNATURE OF OTHERS		56. SIGNATURE OF OTHERS		57. SIGNATURE OF OTHERS	
58. SIGNATURE OF OTHERS		59. SIGNATURE OF OTHERS		60. SIGNATURE OF OTHERS	
61. SIGNATURE OF OTHERS		62. SIGNATURE OF OTHERS		63. SIGNATURE OF OTHERS	
64. SIGNATURE OF OTHERS		65. SIGNATURE OF OTHERS		66. SIGNATURE OF OTHERS	
67. SIGNATURE OF OTHERS		68. SIGNATURE OF OTHERS		69. SIGNATURE OF OTHERS	
70. SIGNATURE OF OTHERS		71. SIGNATURE OF OTHERS		72. SIGNATURE OF OTHERS	
73. SIGNATURE OF OTHERS		74. SIGNATURE OF OTHERS		75. SIGNATURE OF OTHERS	
76. SIGNATURE OF OTHERS		77. SIGNATURE OF OTHERS		78. SIGNATURE OF OTHERS	
79. SIGNATURE OF OTHERS		80. SIGNATURE OF OTHERS		81. SIGNATURE OF OTHERS	
82. SIGNATURE OF OTHERS		83. SIGNATURE OF OTHERS		84. SIGNATURE OF OTHERS	
85. SIGNATURE OF OTHERS		86. SIGNATURE OF OTHERS		87. SIGNATURE OF OTHERS	
88. SIGNATURE OF OTHERS		89. SIGNATURE OF OTHERS		90. SIGNATURE OF OTHERS	
91. SIGNATURE OF OTHERS		92. SIGNATURE OF OTHERS		93. SIGNATURE OF OTHERS	
94. SIGNATURE OF OTHERS		95. SIGNATURE OF OTHERS		96. SIGNATURE OF OTHERS	
97. SIGNATURE OF OTHERS		98. SIGNATURE OF OTHERS		99. SIGNATURE OF OTHERS	
100. SIGNATURE OF OTHERS		101. SIGNATURE OF OTHERS		102. SIGNATURE OF OTHERS	

BUREAU V. S.

JAN 15 1957

RECEIVED

CERTIFICATE OF DEATH

00709

Reg. Dist. No. 182

715

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WHITEFORD		c. LENGTH OF STAY IN 1b 25 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OSCAR Middle CREIG Last TARBERT		4. DATE OF DEATH Month JAN. Day 24 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 11, 1905
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR (If UNDER 24 HRS. Months Days Hours Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REFRIGERATION ENG.		10b. KIND OF BUSINESS OR INDUSTRY FROZEN FOOD	
11. BIRTHPLACE (State or foreign country) YORK CO., PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL TARBERT		14. MOTHER'S MAIDEN NAME MARY GRIMES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. WYVETTA TARBERT,		Address WHITEFORD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary atherosclerosis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 27 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 18, 1957 to Jan 29, 1957 that I last saw the deceased alive on Jan 18, 1957 and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1-26-57			
ACTUAL SIGNATURE BENJAMIN DOROGI, MD.		PHYSICIAN'S NAME (Type) BENJAMIN DOROGI, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-27-57	
22c. NAME OF CEMETERY OR CREMATORY SLATEVILLE		22d. LOCATION (City, town, or county) (State) DELTA, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harrison, Delta, Pa.		24a. REC'D BY REGISTRAR DATE 1-28-57	
24b. REGISTRAR'S SIGNATURE Priscilla Pound			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00710

716

CERTIFICATE OF DEATH

Reg. Dist. No.

182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>S.</u> Last <u>Temple</u>		4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17 1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTH PLACE (State or foreign country) <u>Harford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Alexandra Lee</u>		14. MOTHER'S MAIDEN NAME <u>Mariella Swift</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>16</u>		16. SOCIAL SECURITY NO. <u>220-20-6464</u> 17. INFORMANT <u>Mrs. Alfred Culler</u> Address <u>Street Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-22</u> , 19 <u>57</u> to <u>1-22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-22</u> , 19 <u>57</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> Baltimore Md.		ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u> DATE SIGNED <u>1-23-57</u>	
PHYSICIAN'S NAME (Type) <u>Gerald E Palmer-MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 26, 1957</u>	<u>Hublin Cem</u>	<u>Harford Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		24a. REC'D BY REGISTRAR <u>Jan 25, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>G. E. Kirk</u>

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

RECEIVED
JAN 30 1957
BUREAU V. S.

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>Jan 28 1957</i>
AGE <i>45</i>		SEX <i>M</i>
RACE <i>W</i>		EDUCATION <i>High School</i>
OCCUPATION <i>Teacher</i>		RESIDENCE <i>123 Main St, Baltimore, Md</i>
CAUSE OF DEATH <i>Heart Disease</i>		PLACE OF DEATH <i>Home</i>
MANNER OF DEATH <i>Natural</i>		DATE OF REPORT <i>Jan 30 1957</i>
REPORTED BY <i>Dr. Smith</i>		SIGNATURE <i>[Signature]</i>
OFFICIAL USE		OFFICIAL USE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00711

Reg. Dist. No. 182

717

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air R.D.</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescent Home</u>				d. STREET ADDRESS <u>Emmorton</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>W.</u> Middle <u>Taylor</u> Last <u>Temple</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>7</u> Year <u>19 57</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 16, 1880</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>57</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Mason & Bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Samuel Temple</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Magness</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-16-5490</u>		17. INFORMANT <u>Mrs. Lina R. Temple, Bel Air R.D. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE (second episode)</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. hypertensive Cardio-vascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Forest Hill, Md.</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 1</u> , 19 <u>57</u> , to <u>Jan. 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 6</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>1-8-57</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 10, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Emmorton Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Thomas & Son</u>				ADDRESS <u>Abingdon Md.</u>		24a. REC'D BY REGISTRAR DATE <u>1-11-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowood</u>							

BUREAU V. S.

JAN 15 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

695 CERTIFICATE OF DEATH

00712-185-

Reg. Dist. No.

See: Birth Cert.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Cecil</u>
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	LENGTH OF STAY (in this place)	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Baby</u> (Middle) <u>Boy</u> (Last) <u>Tester man.</u>		(Month) <u>1</u> (Day) <u>5</u> (Year) <u>1957</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Male</u>	<u>white</u>	<u>Baby</u>	<u>November 25, 1956</u>
9. AGE last birthday		IF UNDER 1 YEAR	
yrs. <u>1</u>		Months <u>11</u> Days <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Md.</u>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Arthur Burk Tester man.</u>		<u>Margaret Mozelle (Slagle)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)			
17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
7562 IMMEDIATE CAUSE (A) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pleural infection</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Leaking anastomosis due to repair of</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic emphysema</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<u>11-29-56</u>		<u>Chronic emphysema, bilateral</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-25-56</u> , 19 <u>56</u> , to <u>1-5-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-5-57</u> , 19 <u>57</u> , and that death occurred at <u>10</u> P.M., from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
<u>Wm K. Greider</u>		<u>Harre-de-Grace Md.</u>	
M.D.		DATE SIGNED	
<u>Harre-de-Grace Md.</u>		<u>1-6-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>West Nottingham</u>	
DATE THEREOF		LOCATION (City, town, or county) (State)	
<u>Jan 7 1957</u>		<u>Colora, Cecil Md.</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
DATE <u>Jan 6 - 1957</u>		ADDRESS	
REGISTRAR'S SIGNATURE <u>G. L. Lewis m d.</u>		<u>Earl Tyson, Rising Sun, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy, of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

20X6355XV5

CERTIFICATE OF DEATH

1. CLASS OF DEATH (Type in one of the following)

2. MANNER OF DEATH

3. PLACE OF DEATH

4. SEX (Type in one of the following)

5. AGE (Type in years, months, and days)

6. DATE OF DEATH

7. TIME OF DEATH (Type in hours, minutes, and seconds)

8. CAUSE OF DEATH (Type in the following)

9. MEDICAL CERTIFICATION

10. SIGNATURE OF DECEASED (Type in full name)

11. SIGNATURE OF WITNESSES (Type in full names)

12. SIGNATURE OF PHYSICIAN (Type in full name)

13. SIGNATURE OF CLERK (Type in full name)

14. SIGNATURE OF JURY (Type in full names)

15. SIGNATURE OF JUDGE (Type in full name)

16. SIGNATURE OF SHERIFF (Type in full name)

17. SIGNATURE OF CORONER (Type in full name)

18. SIGNATURE OF JURY (Type in full names)

19. SIGNATURE OF JUDGE (Type in full name)

20. SIGNATURE OF SHERIFF (Type in full name)

21. SIGNATURE OF CORONER (Type in full name)

22. SIGNATURE OF JURY (Type in full names)

23. SIGNATURE OF JUDGE (Type in full name)

24. SIGNATURE OF SHERIFF (Type in full name)

25. SIGNATURE OF CORONER (Type in full name)

26. SIGNATURE OF JURY (Type in full names)

27. SIGNATURE OF JUDGE (Type in full name)

28. SIGNATURE OF SHERIFF (Type in full name)

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63. SIGNATURE OF JUDGE (Type in full name)

64. SIGNATURE OF SHERIFF (Type in full name)

65. SIGNATURE OF CORONER (Type in full name)

66. SIGNATURE OF JURY (Type in full names)

EXCERPTS

This is a copy of the original certificate of death, and is not to be used for any other purpose. It is to be kept in the files of the Department of Health, and is to be made available to the public upon request. It is to be destroyed after ten years from the date of death.

BUREAU V. S.

JAN 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00713

Reg. Dist. No. 1803

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Belt Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Emmorton Road</u>				d. STREET ADDRESS <u>Emmorton Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Berth</u> First <u>L</u> Middle <u>Wann</u> Last				4. DATE OF DEATH <u>January</u> Month <u>23</u> Day <u>1957</u> Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-74</u>	9. AGE (In years last birthday) <u>82</u> yrs.	10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant Store</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Wann</u>				14. MOTHER'S MAIDEN NAME <u>Mellie Hammond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <u>Wm D Amoss Bel Air md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2nd Degree Burns Entire Body</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned in house fire</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p. m. <u>1-23-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Belt Air-Harford md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> Bel Air md.				DATE SIGNED <u>11-23-57</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer md</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Harford County</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Notbarnal Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Emmorton Harford md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Bel Air md</u>				24a. REC'D BY REGISTRAR <u>DATE 1-24-67</u>		24b. REGISTRAR'S SIGNATURE <u>Purcella Lowwood</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

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